

**CONFIDENTIAL****Eye Report for Children with Visual Problems**

R L B

NAME OF PUPIL \_\_\_\_\_ SEX \_\_\_\_\_  
(Type or print) (First) (Middle) (Last)ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(No. and street) (City or town) (County) (State) (Month) (Day) (Year)

GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_ ADDRESS \_\_\_\_\_

**I. HISTORY**

- A. Probable age at onset of vision impairment. Right eye (O.D.) \_\_\_\_\_ Left eye (O.S.) \_\_\_\_\_
- B. Severe ocular infections, injuries, operations, if any, with age at time of occurrence \_\_\_\_\_
- C. Has pupil's ocular condition occurred in any blood relative(s)? \_\_\_\_\_ If so, what relationship(s)? \_\_\_\_\_

**II. MEASUREMENTS**

(See back of form for preferred notation for recording visual acuity and table of approximate equivalents.)

- | A. VISUAL ACUITY | DISTANT VISION     |                       |                     | NEAR VISION        |                       |                     | PRESCRIPTION |       |       |
|------------------|--------------------|-----------------------|---------------------|--------------------|-----------------------|---------------------|--------------|-------|-------|
|                  | Without correction | With best correction* | With low vision aid | Without correction | With best correction* | With low vision aid | Sph.         | Cyl.  | Axis  |
| Right eye (O.D.) | _____              | _____                 | _____               | _____              | _____                 | _____               | _____        | _____ | _____ |
| Left eye (O.S.)  | _____              | _____                 | _____               | _____              | _____                 | _____               | _____        | _____ | _____ |
| Both eyes (O.U.) | _____              | _____                 | _____               | _____              | _____                 | _____               | Date         | _____ | _____ |
- B. If glasses are to be worn, were safety lenses prescribed in: Plastic \_\_\_\_\_ Tempered glass \_\_\_\_\_ \*with ordinary lenses
- C. If low vision aid is prescribed, specify type and recommendations for use. \_\_\_\_\_
- D. FIELD OF VISION: Is there a limitation? \_\_\_\_\_ If so, record results of test on chart on back of form.  
What is the widest diameter (in degrees) of remaining visual field? O.D. \_\_\_\_\_ O.S. \_\_\_\_\_
- E. Is there impaired color perception? \_\_\_\_\_ If so, for what color(s)? \_\_\_\_\_

**III. CAUSE OF BLINDNESS OR VISION IMPAIRMENT**

- A. Present ocular condition(s) responsible for vision impairment. (If more than one, specify all but underline the one which probably first caused severe vision impairment.) O.D. \_\_\_\_\_  
O.S. \_\_\_\_\_
- B. Preceding ocular condition, if any, which led to present condition, or the underlined condition, specified in A. O.D. \_\_\_\_\_  
O.S. \_\_\_\_\_
- C. Etiology (underlying cause) of ocular condition primarily responsible for vision impairment. (e.g., specific disease, injury, poisoning, heredity or other prenatal influence.) O.D. \_\_\_\_\_  
O.S. \_\_\_\_\_
- D. If etiology is injury or poisoning, indicate circumstances and kind of object or poison involved. \_\_\_\_\_

**IV. PROGNOSIS AND RECOMMENDATIONS**

- A. Is pupil's vision impairment considered to be: Stable \_\_\_\_\_ Deteriorating \_\_\_\_\_ Capable of improvement \_\_\_\_\_ Uncertain \_\_\_\_\_
- B. What treatment is recommended, if any? \_\_\_\_\_
- C. When is reexamination recommended? \_\_\_\_\_
- D. Glasses: Not needed \_\_\_\_\_ To be worn constantly \_\_\_\_\_ For close work only \_\_\_\_\_ Other (specify) \_\_\_\_\_
- E. Lighting requirements: Average \_\_\_\_\_ Better than average \_\_\_\_\_ Less than average \_\_\_\_\_
- F. Use of eyes: Unlimited \_\_\_\_\_ Limited, as follows: \_\_\_\_\_
- G. Physical activity: Unrestricted \_\_\_\_\_ Restricted, as follows: \_\_\_\_\_

**TO BE FORWARDED BY EXAMINER TO:**

Date of examination \_\_\_\_\_  
 Signature of examiner \_\_\_\_\_ Degree \_\_\_\_\_  
 Address \_\_\_\_\_  
 If clinic case: Number \_\_\_\_\_ Name of clinic \_\_\_\_\_

## Preferred Visual Acuity Notations

**DISTANT VISION.** Use Snellen notation with test distance of 20 feet. (Examples: 20/100, 20/60). For acuities less than 20/200 record distance at which 200 foot letter can be recognized as numerator of fraction and 200 as denominator. (Examples: 10/200, 3/200). If the 200 foot letter is not recognized at 1 foot record abbreviation for best distant vision as follows:

HM HAND MOVEMENTS (Specify inches or feet)  
 PLL PERCEIVES AND LOCALIZES LIGHT IN ONE OR MORE QUADRANTS  
 LP PERCEIVES BUT DOES NOT LOCALIZE LIGHT  
 No LP NO LIGHT PERCEPTION

**NEAR VISION.** Use standard A.M.A. notation and specify best distance at which pupil can read. (Example: 14/70 at 5 in.)

TABLE OF APPROXIMATE EQUIVALENT VISUAL ACUITY NOTATIONS

These notations serve only as an indication of the approximate relationship between recordings of distant and near vision and point type sizes. The teacher will find in practice that the pupil's reading performance may vary considerably from the equivalents shown.

Distant Snellen	Near			% Central Visual Efficiency for Near	Point	Usual Type Text Size
	A.M.A.	Jaeger	Metric			
20/20 (ft.)	14/14 (in.)	1	0.37 (M.)	100	3	Mail order catalogue
20/30	14/21	2	0.50	95	5	Want ads
20/40	14/28	4	0.75	90	6	Telephone directory
20/50	14/35	6	0.87	50	8	Newspaper text
20/60	14/42	8	1.00	40	9	Adult text books
20/80	14/56	10	1.50	20	12	Children's books 9-12 yrs
20/100	14/70	11	1.75	15	14	Children's books 8-9 yrs.
20/120	14/84	12	2.00	10	18 }	Large type text
20/200	14/140	17	3.50	2	24 }	
12.5/200	14/224	19	6.00	1.5		
8/200	14/336	20	8.00	1		
5/200	14/560					
3/200	14/900					

**FIELD OF VISION.** Record results on chart below.

Type of test used: \_\_\_\_\_

Illumination in ft. candles: \_\_\_\_\_

